2006
Provider Network Form A
and
Integrated Provider Network Database (IPND) - FINAL VERSION

	Fields		Provider Type		Field		Description/Valid Codes/Standard	For Use by	IPND Edit	OIC Edit
	No.	Name	1	2,3,4&9	Type	Width				
Control #	1	RecordControl	x	x	Text	1	Insert the letter "A" into this field. This indicates the beginning of the record.	OIC		TR
Carrier Information	2	Network	x	x	Text	90	Enter the specific name used by the carrier to identify the network. Pattern is **NAIC#_NETWORK,** i.e., **12345_PPO**	Both		TR
	3	ProgramType	x	x	Num	1	Enter the following program types, HO = 1, BH = 2, PEBB = 4, CHIP= 8 for each practitioner, hospital, or pharmacy that participates in each program. For providers not participating in the above government programs, leave this field blank.	IPND	TR	NR
	4	HealthCarrier	x	x	Text	60	Enter the name of the carrier as it appears on the Certificate of Registration.	OIC		TR
	5	NAIC	x	x	Text	5	Enter the five digit NAIC (National Association of Insurance Commissioners) code assigned to the carrier.	OIC		TR
	6	CaEmail	x	x	Text	60	Enter the E-mail address of the person who submits this provider network data. (Confirmation of processing requires a valid e-mail address)	OIC		TR
Provider Information	7	PNPI	x	x	Text	13	Enter the Provider's Employer Identification Number (EIN) assigned by the IRS in the required format ##-####### or National Provider Identifier. Hypen is required. If these are not available, please contact the OIC for approval of an alternate identifier.	Both	Err	TR
	8	LicensePrimary	x	a	Text	10	Enter the professional license number in the format issued by the State of Washington, Oregon, or Idaho. See the attached table for format requirements.	Both	TR	TR
	9	LicenseStatePrimary	x	a	Text	2	Enter the state issuing the professional license. Use only the two character abbreviations, WA, OR, or ID.	Both	TR	TR
	10	InternalProviderID	x	a	Text	15	Enter the carrier's internal identification provider number. Required for PEBB PCPs using ProviderClinicCode (used for enrollment purposes). For providers not participating in the HO, BH, or PEBB government programs, leave this field blank.	Both	Err Prog Type 4 Only	Optional
	11	ProfDegree	x	a	Text	10	Enter the practitioner's professional title as listed on their license (e.g. MD, DO, ARNP, PA, LM, CNM) May be multiple if active.	Both	TR	TR
	12	LastName	x	a	Text	25	Enter the provider's full legal last name.	Both	TR	TR
	13	FirstName	x	a	Text	25	Enter the provider's full legal first name.	Both	TR	TR
	14	MiddleName	x	a	Text	25	Enter the provider's middle initial. Leave field blank if provider does not have a middle initial.	Both	Optional	Optional
	15	Language	a	a	Text	50	If the practitioner speaks other languages than English, enter the Language(s) abbreviations listed on the attached table. If the provider does not speak an additional language, leave this field blank.	Both	Optional	Optional
	16	SpecialtyPrimary	x	a	Text	50	Enter the approved abbreviation of the provider's specialty from the attached table.	Both	TR	TR

2006
Provider Network Form A
and
Integrated Provider Network Database (IPND) - FINAL VERSION

#	Fields		Provider Type		Field		Description/Valid Codes/Standard	For Use by	IPND Edit	OIC Edit
	No.	Name	1	2,3,4&9	Type	Width				
Provider Contract Information	17	SpecialtySecondary	x	a	Text	50	Enter the approved abbreviation of the provider's specialty from the attached table.	Both	Optional	Optional
	18	ProvidesObstetricCare	x	a	Text	1	Enter "Y" if the practitioner offers obstetric services, including birthing. If no, enter "N".	Both	TR	TR
	19	ProvidesPediatricCare	x	a	Text	1	Enter "Y" if the practitioner offers pediatric services. If no, enter "N".	Both	Optional	Optional
	20	PCPSpecialistBoth	x		Text	1	Enter P = Primary Care Provider, S = Specialist, B = Both.	Both	TR	Optional
	21	Limits	x	a	Text	50	Enter the practice limitations the provider places on his/her services (e.g., age 0-19, treats only adults, open 2 days a week). If no limits, leave field blank. For providers not participating in government programs, leave this field blank.	IPND		NR
	22	ProviderType	x	x	Num	1	Enter the correct provider type: 1=Practitioner 2=Hospital 3=Pharmacy 4=Clinic 9=Other. Cannot be blank.	Both	TR	TR
	23	Start	x	x	Date	10	Enter the HO, BH, or PEBB provider contract effective date. Must be in the required format: MM/DD/YYYY. This date may be in the future based on the contract effective date. For providers not participating in the above government programs, leave this field blank.	IPND	TR	NR
	24	End	a	a	Date	10	Enter the HO, BH, or PEBB provider termination date, if known. Must be in the required format: MM/DD/YYY. For providers not participating in the above government programs, leave this field blank.	IPND		NR
	25	Website	x	x	Text	1	Enter "N" for No if this record cannot be published on the IPND web provider directory. If provider is not contracted with the Basic Health Plan, Healthy Options or the Public Employees Benefits Board, leave the field blank.	IPND		NR
Business Information	26	BNPI	x	x	Text	13	Enter the Provider's Employer Identification Number (EIN) assigned by the IRS in the required format ##-####### or National Provider Identifier. Hypen is required. If these are not available, please contact the OIC for approval of an alternate identifier.	Both	Err	TR
	27	BusinessName	x	x	Text	65	Enter the name of Clinic, Office, Hospital or Pharmacy, as listed on its business license.	Both	TR	TR
	28	StreetAddress	x	x	Text	72	Enter the address of the physical location of the Clinic, Office, Hospital or Pharmacy. May not contain Post Office Box numbers or separate billing address. No suite numbers permitted. Please use the accepted US Post Office format (See attached). Please note that this field has been lengthened and StreetAddress2 omitted.	Both	TR	TR
	29	City	x	x	Text	25	Enter the full name of the city in which the business is physically located. Abbreviations will not be accepted.	Both	TR	TR
	30	State	x	x	Text	2	Enter the state the Clinic, Office, Hospital or Pharmacy is physically located. Use only the abbreviations, WA, OR ID.	Both	TR	TR
	31	Zip	x	x	Num	10	Enter the postal ZIP code in which the Clinic, Office, Hospital or Pharmacy is located in the required format: #####.	Both	TR	TR
	32	County	x	x	Text	15	Enter the full name in capital letters of the County in which the Clinic, Office, Hospital or Pharmacy is physically located.	Both	TR	TR
	33	DayPhone	x	x	Num	23	Enter the daytime business telephone number in the required format: (nnn) nnn-nnnn ext. nnnnn. (Telephone extensions are optional)	Both	TR	Length Only